INSTRUCTIONS FOR COMPLETING APPLICATION FOR MEDICAL CARE FACILITY LICENSE

I. IDENTIFICATION

A. Check classification as defined under KSA 65-425. **A critical access hospital must also meet the requirements of KSA 65-468 et seq.**

B. Provide the full legal name and physical address of the facility including the nine-digit zip code.

C. Provide the facility's telephone number, fax number and e-mail address.

D. Identify the person designated by the governing authority to be responsible for the daily management of the facility. This person is usually referred to as the administrator/chief executive officer.

II. CONTROL AND GOVERNING AUTHORITY

A. Give the legal name of the organization that owns or controls this medical care facility.

B. Select the type of entity that describes the type of ownership and control of the facility. In the boxes below, read the information 1 thru 5 and complete the boxes or attach the information.

III. GENERAL INFORMATION

A. **FOR HOSPITALS ONLY:** Indicate all beds, including medical-surgical, rehabilitation, psychiatric, etc. following the word "general." All long-term care beds, including Medicare/Medicaid-certified skilled (SNF) or nursing facility (NF) beds following the words "long-term care."

B. The active medical staff are the physician and dentist members who provide the preponderance of medical practice in the facility and perform all significant medical staff organizational and administrative functions.

C. All categories of medical staff include: active, associate, courtesy, consulting and honorary members.

D. Kansas law currently recognizes only JCAHO and AOA accreditation for hospitals and AAAHC, JACHO and AAAASF for ambulatory surgical centers state licensure purposes.

E. **COMPLETE THIS ITEM ONLY IF ANSWERING "YES" TO ITEM III. D.** If a survey has been conducted during a 12-month period prior to the date of application but the survey results and copy of the survey report have not been received, mark "NO". If the survey was conducted more than 12 months before the application date but the results and survey report were received during the 12-month period, mark 'yes' and **submit the report.**

F. The term "organized" relative to a clinical department or service is one that is an organizational unit or a functional division of the facility or medical staff.

G. **Clinical Laboratory Improvement Act (CLIA) certification.**

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
Bureau of Child Care & Health Facilities
LICENSE APPLICATION FOR MEDICAL CARE FACILITY

9 INITIAL 9 RENEWAL

The undersigned hereby applies to the Kansas Department of Health and Environment for a license to operate a medical care facility subject to provisions of Kansas Law.

I. **IDENTIFICATION**

A. Classification of License Requested: “ General Hospital “ ASC “ Critical Access Hospital “ Special Hospital

B. Name of Facility: ____(Email)________________________

C. Facility Address: ________________________________ City ________________________ Zip _____________

D. Chief Executive Officer: ______________________________ Phone _________________ Fax _______________

II. **CONTROL AND GOVERNING AUTHORITY**

A. Disclosing Entity’s Name: _________________________________ Address ______________________________

B. Type of Entity “ 1. Sole Proprietorship “ 2. Partnership “ 3. Joint Venture “ 4. Corporation for profit “ 5. Corporation not for profit

“ 6. Government - Type ____________________ “ 7. Other (Explain) ___________________ “ 8. Limited Liability Company

COMPLETE THE BOXES BELOW WITH THE INFORMATION AS FOLLOWS FOR THE DISCLOSING ENTITY LISTED ON LINE A ABOVE.

1. List the name (s) and address(es) of each person who has any direct or indirect ownership of **10 percent** or more in entity listed above.
2. List each person who is the owner (in whole or in part) of any mortgage, deed or trust, note or other obligation secured (in whole or in part) by such facility or any of the property or assets of such facility.
3. If the disclosing entity is organized as a corporation, attach a list showing the names and address of each officer and director.
4. If the disclosing entity is organized as a limited partnership or limited liability company, please describe each limited liability for each 5 percent owner, and for all general partners.
5. If the disclosing entity is a governmental unit, attach a list showing the names and addresses of each responsible official (i.e., county commissioner).

INDICATE WITH “X”					INDIVIDUAL NAME	ADDRESS	CITY	STATE
1. OWNER	2. MORTGAGOR	3. DIRECTOR/OFFICERS	4. LIMITED LIABILITY Describe for each limited partnership & LLC the limited liability for each 10 % owner, and for all general partners.	5. ELECTED OFFICIALS				

AGENCY USE ONLY DO NOT WRITE BELOW THIS LINE

License ID No. ______________________________ Effective Date ______________________________

Approved By ______________________________ Renewal Date ______________________________

III. GENERAL INFORMATION

A. **(FOR HOSPITALS ONLY)** Number of Beds: general _______ long-term-care _______ bassinets _______

B. Number of Active Medical Staff _______

C. Total Number of All Categories of Medical Staff _______

D. This facility is currently accredited? ______________________

By whom? ____

E. Accreditation survey has been conducted during the 12 months prior to the date of this application and a copy of the survey report ("Recommendations for Future Compliance") is attached to this application to be used in lieu of an onsite survey by the licensing agency for verification of compliance with licensing regulations:

" YES " NO

F. The licensing regulations include standards for optional organized services, departments, or units. Check those below that are provided by your facility.

" surgery department
" obstetrical department
" pediatric department
" outpatient department
" psychiatric department
" physical therapy department
" inhalation/respiratory therapy department
" dialysis
" social services department
" occupational therapy department
" tuberculosis treatment
" alcoholism treatment
" intensive/coronary care units
" long term care units
" radiology

G. This facility's laboratory or laboratories performing analytical tests holds a valid Clinical Laboratory Improvement Act (CLIA) certificate for the type and complexity of all tests performed.

" YES " NO

THE UNDERSIGNED IS AUTHORIZED TO REPRESENT THE GOVERNING BODY, CORPORATION, ORGANIZATION, INDIVIDUAL, OR PARTNERSHIP IN WHOM IS VESTED THE RESPONSIBILITY FOR OPERATION OF THE FACILITY AND CERTIFIES THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.

______________________________________ ______________________________________
Signature Title Print Name

______________________________________ ______________________________________
Date Telephone Number

Return to: Kansas Department of Health and Environment, Licensure Program, Bureau of Child Care & Health Facilities
1000 SW Jackson St. Suite 200, Topeka KS 66612-1365
Phone Number (785) 296-1240 Fax Number (785) 291-3419